EXHIBIT "A"

Facility : Saint Francis Hospital
Patient Name : Dooly, Carrie Melynda
Med Rec # : 106825
Visit # : 986386282
DOB : [redacted]
Sex : F
Attending Physician: Markman, Bruce S MD
Admission Date/Time: 07/25/2013 0610
Disharge Date/Time : 07/25/2013 1609

Report Type : Orthopedic Surgery
Test Date/Time : 07/25/2013 1059

Requested By : Markman, Bruce S MD
Accession # :
Dictating Physician: Markman, Bruce S Dr MD
Dictation Date/Time: 07/25/2013 0000

DATE OF PROCEDURE: 07/25/2013

PREOPERATIVE DIAGNOSES:
1. Partial-thickness rotator cuff tear of left shoulder.
2. Left subacromial impingement syndrome.
3. Left acromioclavicular joint arthropathy.

POSTOPERATIVE DIAGNOSES:
1. Partial-thickness rotator cuff tear of left shoulder.
2. Left subacromial impingement syndrome.
3. Left acromioclavicular joint arthropathy.
4. Partial biceps tendon tear of the left shoulder.

PROCEDURE: Left shoulder arthroscopy including (A) Arthroscopic rotator cuff repair, (B) Arthroscopic biceps tenodesis, (C) Arthroscopic distal clavicle resection, and (D) Arthroscopic subacromial decompression/acromioplasty.

Surgeon: Bruce S. Markman, MD.

Assistant: Crista Hobbs, PA-C.

Anesthesia: General plus local plus regional, interscalene nerve block type.

Complications: None.

Blood Loss: Less than 50 mL.

Implants used: Include the Biomet 2.9 mm JuggerKnot suture anchor x1 with multiple number 2 MaxBraid sutures for both the rotator cuff repair and biceps tenodesis.

Drains: No drains placed.

INDICATIONS: A 35-year-old woman with chronically worsening left shoulder pain and disability. She had failed nonsurgical treatment and outpatient workup including CT arthrogram because an MRI could not be obtained did reveal no definitive full-thickness tearing but partial-thickness tearing was possible. A complete discussion of risks, benefits, and alternatives to surgery was undertaken with the patient. She understood the risks of surgery and did wish to proceed because of failed nonsurgical treatment. Therefore, an informed consent was obtained prior to surgery.

EXHIBIT "A"

Findings at surgery: The initial examination under anesthesia revealed external rotation at the side of the body of nearly 70 degrees with internal rotation also 70 degrees in the abducted posture. Range of motion was reasonably symmetric to the opposite side. The shoulder was stable and stability testing was also symmetric to the opposite side. The diagnostic arthroscopy revealed normal appearance of the articular surface of the humeral head and glenoid fossa. No significant degenerative articular changes were identified. The labral tissue anteriorly, inferiorly, posteriorly and superiorly all appeared to be stable. However, there was some hypoplasia of the anterior labrum. There was evidence of a capsular redundancy with a significant capacious axillary recess and even in the posterior gutter. This was felt to be normal anatomy for this patient. No labral instability was identified. The biceps anchor was stable. The biceps tendon did show partial tearing along the inferior aspect near the bicipital groove. There was also partial articular-sided tearing of the subscapularis tendon and of the supraspinatus tendon. The subscapularis tendon did show only about a 15% tear on the articular side, but it did seem to cause some laxity in the bicipital sling and with the amount of damage in the biceps tendon, it was felt that a biceps tenodesis was necessary to avoid ongoing pain from the biceps tendon complex. In addition, the articular-sided tear of the supraspinatus tendon was noted that amounted to as much as 35% to 40%, also very close to the bicipital groove. The tendon tearing was debrided. The bursal-sided fibers of the supraspinatus and subscapularis appeared to be normal but because of the extensive damage to the supraspinatus and compromise of its thickness, it was felt that an articular-sided tear was necessary to help limit the risk of ongoing pain from the extent of compromise to the supraspinatus tendon. At that point, a trans-tendinous articular-sided repair was performed. An anchor was placed through the tendon as the rotator cuff footprint in this area was decorticated. The amount of exposed rotator cuff footprint amounted to at least 5-6 mm. It measured about 0.5 cm from anterior to posterior. Again, the bone was decorticated and the tendon itself was debrided. Then, through a trans-tendinous approach in the area of injury, the suture anchor was placed directly along the articular margin. The suture limbs were then passed using a suture lasso medial to the zone of injury consistent with a medial row repair. A total of 4 suture limbs were passed, creating 2 horizontal mattress sutures and 2 of these suture limbs were passed through the biceps tendon as well. One suture limb from each one of the knots was used creating a type of locking stitch in the biceps tendon within the zone of repair of the rotator cuff tendon as well. This created an entire construct that was confluent and between the biceps and rotator cuff, securing both tendons under the bone. The sutures were tied over the top of the rotator cuff on the bursal side on direct visualization of the subacromial space, and then a second look arthroscopy in the joint did reveal excellent stability to the repair at both the rotator cuff tendon and the biceps tendon as well. Again, at that point, the biceps tenodesis and rotator cuff repair were felt to be stable through a full range of motion under direct visualization arthroscopically. The subacromial space was further evaluated. Chronic hyperemic bursitis was encountered. This was debrided aggressively. Then, the acromion was exposed. There was a significant anterior and anterolateral overhang. An acromioplasty was performed by first contouring the lateral edge, creating a lateral trough, and then performing anterior resection using a posterior cutting block technique effecting a type 1 acromion visualized arthroscopically for a very satisfactory subacromial decompression. The entire bursal side of the rotator cuff was scrutinized. The entire bursal-sided cuff was intact. The AC joint was evaluated and

the distal end of the clavicle was noted to be severely arthritic with inferior osteophyte formation. Therefore, a formal distal clavicle resection was performed by performing inferior coplaning and complete resection of the distal articular surface establishing a centimeter of AC joint space while preserving the stabilizing ligaments of the AC joint. This adequately decompressed both the AC joint and the supraspinatus outlet.

It should be noted that Crista Hobbs, PA-C, played a critical role in the operation ensuring that the entire procedure was performed smoothly and safely. She helped manipulate the limb and maintained position of the limb during the procedure to ensure that all areas were adequately visualized. She also facilitated careful passage of instruments, anchors, and sutures in and out of the portal sites and in and out of the tendinous repair for a very safe and secure rotator cuff repair and biceps tenodesis.

DESCRIPTION OF PROCEDURE: Once informed consent was obtained from the patient, she was taken to the operating room and laid supine on the operating table. The regional block was noted to be satisfactory. Therefore, appropriate intravenous prophylactic antibiotics were administered, and all bony prominences were padded well. Then, general anesthesia was achieved following which the patient was carefully manipulated into the modified beach chair position with the head secured in a headrest and a bump under the knees. The initial examination under anesthesia of the left shoulder was performed with findings as previously described. The left upper extremity was then prepped and draped in usual sterile fashion from the tips of the fingers to the neck. The bony landmarks were mapped out on the skin and the McConnell arm positioner was used. Portal sites for the arthroscopy were all infiltrated with local anesthetic with epinephrine and all portal sites were established in standard fashion using a small stab incision and placement of a blunt obturator to penetrate the joint capsule. The arthroscopy began with the use of routine posterior portal established while maintaining lateral traction on the humerus. The joint was insufflated as the arthroscope was introduced. Then, the anterior working portal was established in an outside-in technique and secured with a disposable threaded cannula. The diagnostic arthroscopy then ensued. The synovitis was debrided in the joint. The rotator cuff tearing of the subscapularis and supraspinatus tendons was also debrided and the biceps tendon injury was identified. Then, the bone was decorticated along the area of the supraspinatus injury and the initial steps of the articular-sided repair of the rotator cuff was performed, also including the biceps tenodesis with the technique of suture passing through both tendons. Once the sutures were secured on the articular side with the anchor, then the biceps tendon was released from the supraglenoid tubercle and further debrided in the joint all the way down the supraglenoid tubercle. Then, the posterior portal was redirected into the subacromial space. A lateral portal was established at this time. Through the posterior and lateral portals, the bursectomy was performed initially. The suture limbs were retrieved in the subacromial space and subsequently tied over the top of the rotator cuff completing the Pasta repair of the rotator cuff and also completing an effective biceps tenodesis. Then, a second look arthroscopy in the joint while redirecting the posterior portal also revealed excellent stability to both repairs. Then, the posterior portal was again redirected into the subacromial space and through the posterior and lateral portals, the acromioplasty was completed to effectively complete the subacromial decompression. Then, the anterior working portal was redirected at the AC joint and while viewing from the posterior portal, the distal clavicle resection was

performed through the anterior working portal. Then, final images were obtained and the procedure was concluded. Instruments were removed from the shoulder and the shoulder was drained. Portal sites were closed at the skin with nylon suture. The wounds were dressed with standard sterile dressings and secured in place with Tegaderm. Drapes were removed as the arm was placed in a pillow sling. The patient was recovered from general anesthesia, extubated, and safely moved to recovery room awake, alert, and in stable condition. Of note, needle and sponge counts were correct at the end of the case. Again, no complications.

Postoperatively, the patient will be discharged to home to follow up as an outpatient and will start home exercises by postoperative day #1 as per protocol.

Bruce S. Markman, MD

DOOLY, CARRIE MELYNDA MRN 20179304
DD: 07/25/2013 11:59:26 CST
DT: 07/25/2013 13:29:15 CST/MIS1217/7417148
JOB: 3235904

cc: Bruce S. Markman, MD

Electronically signed by BRUCE S. MARKMAN MD on 07/26/2013 08:00 AM

EXHIBIT "B"

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4904

SEND original +4 copies to:
Workers' Compensation Court

FILED
OCT 14 2013
WORKERS COMPENSATION COURT
TULSA

Name of Claimant (injured employee)
Carrie M. Dooly

Name of employer
Harvard Family Physicians

Court Use Only
Farmington Can

Please Check (☒) the appropriate box
☒ I. This is an Original Filing of the Form 3
☐ II. This Amends a Previous filing of the Form 3

EMPLOYEE'S FIRST NOTICE OF ACCIDENTAL INJURY AND CLAIM FOR COMPENSATION

COURT CLAIM # 2013-11191R

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8600 or In-State Toll Free (800) 522-8210.

(Please type or print)

EMPLOYEE NAME (last,first, middle):	Social Security #:	Phone:
Dooly , Carrie M.	442-76-9667	918 693-9575

Mailing Address (include City, State,& Zip	Date of Birth:	Age	Sex:
528 N. Sweet Gum Ave Broken Arrow , Ok 74012	11-9-1977	35	Female

Occupation:	Was your employment agreement made in Oklahoma?	Average Weekly Wage	Length of Employment
Diagnostic Tech	☒ Yes ☐ No		months years 1

Date of Accident or as applicable, Date of Termination from Employment if a Cumulative Trauma Injury:	Injury Resulted From:	Time:
5 29 2013	☒ Single Incident ☐ Cumulative Injury	

Describe parts of the body injured or affected:	Place of Injury: City/County/State
Left shoulder and arm	

What is the Nature of the injury or illness	Describe w/ details how the injury occurred. Include object or substance which directly injured you.
	Lifting a 400 pound patient

Have you filed a claim for Social Security Disability Insurance Benefits? ☐ Yes ☒ No

Are you eligible for Medicare Benefits or will you become eligible for Medicare Benefits within 30 months of the filing of this Notice of Accidental Injury and Claim for Compensation? ☐ Yes ☒ No

Are you a previously impaired person due to a prior workers' compensation injury or obvious and apparent pre-existing disability? _____ If "YES", you may be entitled to benefits for combined disabilities against the Multiple Injury Trust Fund. A claim against the Multiple Injury Trust Fund may be commenced by filing a "Form 3F" with the Workers' Compensation Court.

Treating Physician (full name):	Address:	City	State	Zip

Employer: Harvard Family Physicians Telephone:

Complete Mailing Address: 37th & Memorial Tulsa Ok

Complete Street Address (if different from above):

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier any change in a material fact or the amount of income he is receiving or any change in his employment status occuring during the period of receipt of such benefits.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Name of claimant's attorney if represented

Type or Print Name of Attorney	OBA #
Michael R. Green	13397

Mailing Address: 3739 East 31st Street

City	State	Zip
Tulsa,	Oklahoma	74135-1506

Telephone #: (918) 743-2500

by: _____
Signature of Attorney for Claimant

Attorney Lien Claimed

Upon filing this Notice of Accidental Injury and Claim for Compensation permission is given to the Administrator of the Worker's Compensation Court, the Insurance Commissioner, the Attorney General, a district attorney or their designees to examine all records relating to the notice. The permission granted to the above named individuals or their designees authorizes them access to medical records pursuant to 76 O.S., §19, including waiver of any privilege granted by law concerning communications made to a physician or health care provider or knowledge obtained by such physician or health care provider by personal examination. This form is not intended for use as a medical authorization. Nothing shall be construed to waive, limit or impair any evidentiary privilege recognized by law.

I declare under penalty of perjury that I have examined this notice and claim for compensation and all statements contained herein are true, correct and complete to the best of my knowledge and belief.

Signed this _____ day of _____ 2013

Carrie M. Dooley
Signature of Claimant

EXHIBIT "B"

EXHIBIT "C"

St John Broken Arrow	*CONFIDENTIAL*	*Preliminary Report*

OPERATIVE REPORT

PATIENT:	DOOLY,CARRIE M	TYPE:	Ob
ACCT:	33827831	ROOM #:	4MEDSURGBA 421
MRN:	B12444204	ADM DATE:	06/24/2014
DOB:	[redacted]	DIS DATE:	
DATE OF PROCEDURE :	06/24/2014		

PREOPERATIVE DIAGNOSIS:
Left shoulder pain, status post soft tissue biceps tenodesis and rotator cuff repair.

POSTOPERATIVE DIAGNOSIS:
Left shoulder retained painful sutures, severe scarring subacromial space.

PROCEDURE:
Repeat acromioplasty.

ANESTHESIA:
General, interscalene block.

SURGEON:
Antoine Jabbour, M.D.

COMPLICATIONS:
None.

DESCRIPTION OF PROCEDURE:
After informed consent was obtained, the patient was taken to the operating room and placed in position. General anesthesia was administered. The patient was given 1 gram of Ancef. The left upper extremity was examined. The patient was noted to have full range of motion, no adhesive capsulitis, no instability. The patient was then placed onto the right lateral decubitus position. All pressure points were well padded. The left upper extremity was then placed in contraction. Bony landmarks were then identified. The arthroscope was then placed into the glenohumeral joint near the posterior portal. The humeral head and glenoid were well visualized. The biceps tendon was noted to be absent. There were 2 different sutures that were identified along the subscapularis and supraspinatus tendon region. These were very loose and they were cut and one of them was removed easily. The second one, the knot was on the subacromial side and was later on removed via the subacromial space region. The rotator cuff was noted to be intact. The arthroscope was then placed into the subacromial space and initially there was significant scarring. There was significant difficulty seeing the rotator cuff. There was significant scarring anteriorly between the deltoid and the rotator cuff. This was then debrided with a 480 shaver as well as the heat wand. There was also significant scarring at the coracoacromial ligament region and this was then debrided. The acromioplasty was then performed. Then after debriding the extensive scarring overlying the rotator cuff, the rotator cuff was noted to be intact. A decision was made at that time not to proceed with open biceps tendon exploration since what she had intra-articularly as well as in the subacromial space definitely could explain all the pain that she was in. At this point the wounds

COPY

EXHIBIT "C"

PATIENT: DOOLY,CARRIE M ACCT: 33827831

were then closed in layered fashion. A sterile dressing was applied. The patient was then transferred to the recovery room in stable condition.

Dictated by: Antoine I Jabbour, MD

DD: 06/24/2014 12:48
DT: 06/24/2014 13:16
JOB # 025967
Dictation ID # 126050
Edited By: us103764

Documents of this type are to be considered DRAFTS unless signed [result status: auth(verified)] by the appropriate physician

EXHIBIT "D"

Progress Note

Patient Name:	Carrie Dooly	**Visit Date:**	October 23, 2014
Patient ID:	100362	**Provider:**	Antoine I. Jabbour, MD
Sex:	Female	**Location:**	TBJ Main
Birthdate:	[redacted]	**Location Address:**	4802 S 109th E Ave Tulsa, OK 741465822
		Location Phone:	(918) 392-1400

History Of Present Illness

Ms. Dooly is now four months status post left shoulder revision surgery.

Ms. Dooly states that she is much better as compared to before. She still has some weakness in her biceps. However, overall, she is much better.

Review of Systems

Constitutional
- **Denies :** fever, chills

Gastrointestinal
- **Denies :** nausea, vomiting

Vitals

Date	Time	BP	Position	Site	L\R	Cuff Size	HR	RR	TEMP(°F)	WT	HT	BMI kg/m²	BSA m²	O2 Sat	HC
10/23/2014	01:30 PM	106/60	Sitting							117lbs 0oz	5' 0"	22.85	1.5		

Physical Examination

On physical examination, the left shoulder reveals that she has full forward flexion, full abduction. She has symmetric internal rotation as well as external rotation. She does have some weakness in her biceps. However, most of the pain that she had preoperatively is pretty much gone.

Assessment

- Impingement syndrome left shoulder 726.2
- Left Shoulder Pain 719.41

Status post left shoulder revision shoulder doing great.

Plan

Disposition
- Work Status Form completed

EXHIBIT "D"

[Digital Signature Validated]

Ms. Dooly is being discharged at this time. She is to return to work full duty without limitations. She has reached maximum medical improvement on 10/23/2014.

I declare, under penalty of perjury, that I have examined this report and all the statements contained therein and, to the best of my knowledge and belief, they are true, correct, and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Antoine I. Jabbour, MD

AJ/cg/24213458

Electronically Signed by: Antoine I. Jabbour, MD -Author on October 27, 2014 10:13:44 AM

[Digital Signature Validated]

Adj: Gina Leon F 877-786-0577 1003202

TULSA BONE & JOINT ASSOCIATES

☐ 4802 South 109th East Ave. • Tulsa, OK 74146
☐ 4812 South 109th East Ave. • Tulsa, OK 74146
☐ 12455 East 100th St. North • Owasso, OK 74055
Phone: (918) 392-1400 • www.tulsaboneandjoint.com

John C. Bakas, M.D.
Jaafar M. Bazih, M.D.
William C. Clark Jr., M.D.
Marcy W. Clements, D.O.
Richard L. Drake, D.O.
Kevin M. Dukes, M.D.
Jules Dumais, M.D.
Scott J. Dunitz, M.D.
James L. Griffin, M.D.

~~Ronald G. Hood, M.D.~~
A.I. (Tony) Jabbour, M.D.
John F. Josephson, M.D.
Brian Lovelace, M.D.
Thomas A. Marberry, M.D.
Christopher Martin, M.D.

Brent C. Nossaman, D.O.
Caleb Nunley, M.D.
Paul D. Peterson, M.D.
James C. Slater, M.D.
Richard M. Stamile, M.D.
Keith L. Stanley, M.D.

Wesley M. Stotler, D.O.
Richard D. Thomas, M.D.
Brian Carter, PA-C
Jessica Ferguson, PA-C
Jason Gates, PA-C
Ashley Legg, PA-C
LeAnne Odom, PA-C
Jason Stone, PA-C

Patient: Carrie Body Clm EYZ 3026

Date: 10/23/14 ☐ NO SHOW ☐ Cancelled appointment

DX: (L) Shoulder

WORK STATUS:

☐ No work/school at this time

☒ May return to work/school with the following restrictions:

RESTRICTIONS: ☐ Right ☒ Left ☒ Temporary ☐ Permanent

☒ NONE/REGULAR DUTY
☐ IF RESTRICTIONS CANNOT BE ACCOMODATED, THEN THE PATIENT CONSIDERED TTD
☐ No use of upper extremity ☐ No use of lower extremity
☐ No use of hand
☐ No lifting over ______ pounds
☐ No repetitive lifting over ______ pounds
☐ No reaching: ____ overhead ____ above chest ____ away from body
☐ No repetitive overhead activity
☐ No pushing / pulling over ______ pounds
☐ No prolonged standing or walking
☐ No prolonged sitting
☐ No kneeling ____, squatting ____, climbing ____, stooping ____
☐ No excessive bending or twisting
☐ Sit down job only
☐ May not drive or operate machinery
☐ Splint required: ____ at all times ____ at work ____ night
☐ Crutches required
☐ Medications may cause drowsiness
☐ The following Diagnostic Test (s) recommended: ______
☐ Surgery recommended: ______
☐ Other: ______

F/U Ø

Expected full duty release on: ______ Patient is considered MMI effective: 10/23/2014

Patient Signature: ______

Physician Signature: [signature]

00-WS-R

EXHIBIT "E"

Central States Orthopedic
6585 S. Yale Ave Ste 200 Tulsa, OK 74136
(888)269-2767 Fax: (918) 481-7611

CARRIE M DOOLY
Female DOB: 11/09/1977

Home: (918)693-9575

Account# : 718499-1-CSO

11/25/2014 - Office Visit: DEN RM 46 LT SHLD NUPT
Provider: David E Nonweiler MD
Location of Care: Central States Orthopedic William Office

History of Present Illness:

CARRIE is a 37 year old female who comes in for a new patient visit today. She presents for left shoulder pain. The patient states this condition is work related. Her symptoms have been present for 1.5 years. Associated symptoms include swelling, clicking, popping, nocturnal awakening, and limited ROM. Her injury occurred on or about 05/29/2013, when she had a patient pull on her arm. She had a left shoulder surgery performed by Dr Markman on 7/25/2013. Her arthroscopic pictures are available but her operative note is not. She had a subacromial decompression and biceps tendon tenotomy. She states that she did not improve with this surgery. She had a second surgery by Dr Jabbour which gave her 85% relief. She states that she has regained almost all of her shoulder range of motion back, but still has some stiffness and weakness. She states that she has been released to work full duty, but has not returned to work yet. She is here for a second opinion. She is currently employed as a CT Tech with Harvard Family Physicians. She states she is right hand dominant.

She describes her pain as sore and mild to severe. Her pain is worse with activities. On a scale of 0-10, with 0 being no pain and 10 being the worst pain imaginable, her pain level today is a 2. At its least, her pain is a 2, and at its worst it is an 8. Her symptoms are worse when lifting, reaching, and performing overhead activities. She cannot have an MRI due to her neurostimulator.

She notes improvement in her symptoms with NSAIDS and narcotic medication. Overall she is 85% better since her injury.

Past Medical History
Anemia, Lung problems, Migraines , Gastrointestinal, Reflux, Neuropathy, Arthritis.

ALLERGIES: MORPHINE (Critical)
* GLUTEN (Critical)
ERYTHROMYCIN (Critical)
KEFLEX (Critical)
BACTRIM (Critical)
ADHESIVE PAPER (ADHESIVE TAPE) (Critical)
SULFA (Critical)
* LATEX (Critical)

MEDICATIONS: ALLEGRA ALLERGY TABS (FEXOFENADINE HCL TABS) Historical
NORCO TABS (HYDROCODONE-ACETAMINOPHEN TABS) Historical
MULTIVITAMINS CAPS (MULTIPLE VITAMIN) Historical
MOTRIN IB TABS (IBUPROFEN TABS) Historical
FIORICET CAPS (BUTALBITAL-APAP-CAFFEINE CAPS) Historical
PERCOCET TABS (OXYCODONE-ACETAMINOPHEN TABS) Historical
* MIDRIN Historical

Medication list reviewed with patient for accuracy

Past Surgical History
History of Orthopedic surgery , Tubal ligation.

EXHIBIT "E"

Central States Orthopedic
6585 S. Yale Ave Ste 200 Tulsa, OK 74136
(888)269-2767 Fax: (918) 481-7611

CARRIE M DOOLY
Female DOB: 11/09/1977
Account# : 718499-1-CSO
Home: (918)693-9575

Gastric neuro stimulator
nissen fundoplication
Details of pertinent Orthopedic Surgery:
Procedure: left shoulder surgery Date: 07/25/2013 Surgeon: Dr Markman
Procedure: Left shoulder repeat acromioplasty Date: 06/24/2014 Surgeon: Dr Jabbour

Family Medical History
Anemia, Lung problems, Arthritis, Migraines , Gastrointestinal, Reflux, Neuropathy, Cancer, Depression, Sleep Apnea.

Social History
Living Arrangements: family
Marital Status: married
Tobacco Use: never smoker
Alcohol Use (yes)
Type: wine
Drug Use (No)

Review of Systems

General: Patient denies weight loss, weight gain, fatigue, fever.
Eyes: Patient denies blurring, vision loss.
ENT: Patient denies difficulty breathing, deafness, hoarseness, hearing aid, dentures.
Cardiovascular: Complains of palpitations.
Respiratory: Complains of coughing, shortness of breath.
Gastrointestinal: Complains of abdominal pain, nausea, diarrhea, constipation.
Musculoskeletal: Complains of muscle weakness, back pain, joint pain, joint swelling.
Genitourinary: Complains of urinary frequency.
Skin: Complains of rashes, itching.
Neurologic: Complains of numbness/tingling in arms/legs.
Psychiatric: Complains of difficulty sleeping, anxiety.
Endocrine: Complains of heat or cold intolerance.
Heme/Lymphatic: Patient denies easy or excessive bruising, chills, swelling of lymph nodes, history of blood transfusion, sweats.
Allergic/Immunologic: Complains of latex allergy, hives, hay fever.

Physical Exam

Vital Signs
Ht: 60ins **Wt:** 120lbs **Pulse rate:** 78 **BP:** 120/59 **Resp:** 16
Body Mass Index: 23.52

Constitutional:
General appearance: alert, well nourished, well hydrated, no acute distress
Eyes:
External: conjunctivae and lids normal
Pupils: equal and round
Cardiovascular:
Peripheral pulses: pulses 2+, symmetric
Periph. circulation: no cyanosis, clubbing or edema
Lymphatic:
Misc. lymph nodes: no adenopathy in area of examination

Central States Orthopedic
6585 S. Yale Ave Ste 200 Tulsa, OK 74136
(888)269-2767 Fax: (918) 481-7611

CARRIE M DOOLY
Female DOB: [redacted]

Account# : 718499-1-CSO

Home: (918)693-9575

Skin:
Skin Inspection: no rashes, lesions in area of examination
Skin Palpation: no subcutaneous nodules or induration in area of examination
Neurologic:
Reflexes grossly intact, symmetric
Sensation: intact to touch
Psychiatric:
Orientation: oriented to time, place and person
Memory: intact
Mood and affect: no depression, anxiety

Left Shoulder Exam
Inspection
Pain/Tenderness
mild
Swelling
none
No signs or symptoms of infection
Neurovascularly intact
Active ROM
flexion: 180 degrees / opposite side: (190 degrees)
external rotation: 60 degrees / opposite side: (80 degrees)
internal rotation: T-8 / opposite side: (T-9)
Passive ROM
flexion: same as active / opposite side: (same as active)
external rotation: same as active / opposite side: (same as active)
internal rotation: same as active / opposite side: (same as active)
Muscle Strength & Tone
External Rotation Strength: 5/5
Supraspinatus: 5/5
Abduction: 5/5
Subscapularis: 5/5
Internal Rotation Strength: 5/5
Atrophy: none
Testing
Hawkin's: negative
Jobe's: negative
O'Brien's: positive

Jobe's testing mildly painful
Occasional popping with O'Brien's testing
Well healed surgical incisions

Left Shoulder X-ray
Post-Surgical Description: satisfactory acromioplasty
X-ray taken: XR- Shoulder Min 2v [CPT-73030]

Impression:
Diagnosis:
1. LEFT SHOULDER PAIN S/P ARTHROSCOPY (ICD-719.41) (ICD10-M25.519).

Central States Orthopedic
6585 S. Yale Ave Ste 200 Tulsa, OK 74136
(888)269-2767 Fax: (918) 481-7611

CARRIE M DOOLY
Female DOB: [redacted]

Account# : 718499-1-CSO

Home: (918)693-9575

Plan:

I reviewed the results of the patient's x-ray. I provided explanation and reassurance to the patient. I discussed appropriate treatment options with the patient. I reviewed the above findings with the patient. I discussed with the patient that I believe she may return to work at this point. I believe her shoulder has improved as much as it will after surgery. No medications were prescribed during this visit. The patient may return to activity as tolerated. The patient was advised to return as needed. I have recommended the patient continue an exercise program at home. I do not feel that she is at an increased risk for further injury at this point. However an FCE would give objective data as to her capacity to do her actual job. I called and discussed this with Dr. Schwartz with the patients approval.

This opinion is given within a reasonable degree of medical certainty.

I declare under penalty of perjury that I have examined this report and notice, and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.

PFS History, ROS and Vitals Obtained by: Lora D Ecker RMA, November 25, 2014 1:11 PM

Electronically Signed by David E Nonweiler MD on 11/25/2014 at 3:12 PM